



APPROVAL PACKET

for

Advanced Emergency Medical Technician (AEMT) Training Program



Advanced Emergency Medical Technician (AEMT) Training Program

Approval Packet

California regulations require ICEMA to review prospective training programs to assure compliance with State regulations prior to approving the eligible institution's training program. Only approved training programs may offer the training listed below. The purpose of this document is to define the application requirements for Advanced Emergency Medical Technician (AEMT) Training Program approval.

REQUIREMENTS FOR ADVANCED EMT TRAINING PROGRAM APPROVAL:

The eligibility and program requirements for Advanced Emergency Medical Training Programs are listed in California Code of Regulations, Title 22. Social Security, Division 9. Prehospital Emergency Medical Services, Chapter 2. Advanced Emergency Medical Technician, Article 3. Sections 100101 - 100130 and referenced in the attached application and checklist.

Complete and submit ICEMA AEMT Training Program approval forms and checklist for AEMT Training Program Approval.

AEMT TRAINING PROGRAM

I. PROCEDURES

- A. Complete and submit the following to ICEMA:
 - Application for AEMT Training Program Approval
 - Applicable Fees (See ICEMA Fee Schedule)
 - Checklist for AEMT Training Program Approval
 - Hospital/Ambulance Affiliation Information Form
- B. The following should be retained by the Training Institution:
 - Certification Exam, i.e., passing grade
 - Attendance requirements, etc.
 - Certification Exam Eligibility, Clinical Time Verification Form
- C. Submit to ICEMA after completion of each course:
 - The ICEMA approved Training Course Record must be submitted within 15 days of course completion, typed or printed, and alphabetized.
- D. Submit to ICEMA by July 15 each year:
 - Summary of Training Program Student Completion

Application for AEMT Training Program Approval

☐ New ☐ Renewal ☐ Update ☐ Transition Course

Program Name _____

Mailing Address _____ City _____ ST _____ ZIP _____

Training Site(s) Address _____ City _____ ST _____ ZIP _____

Phone _____ FAX _____

Website _____ Email _____

Course Director _____ Title _____

Email _____

License Number _____ Type _____

Include evidence of 40 hours in teaching methodology or equivalent per COR Title 22, Division 9, Chapter 2, §100150 (C5)

Clinical Coordinator _____ Title _____

Email _____

License Number _____ Type _____

Principal Instructor _____ Title _____

Email _____

License Number _____ Type _____

Include evidence of 40 hours in teaching methodology or equivalent per COR Title 22, Division 9, Chapter 2, §100150 (C5)

Teaching Assistant _____ Title _____

Email _____

License Number _____ Type _____

Teaching Assistant _____ Title _____

Email _____

License Number _____ Type _____

Attach copies of current resumes, CVs, licenses and qualifications for all personnel.

Attach Hospital and EMS Service Provider Contracts for clinical and field training.

Provider type (check one) <input type="checkbox"/> Branch of the Armed Forces <input type="checkbox"/> Accredited College or University <input type="checkbox"/> Licensed general acute care hospital <input type="checkbox"/> Public safety agency <input type="checkbox"/> Private post-secondary school <input type="checkbox"/> Other: Specify _____	Type of Training Offered (Check all that apply) <input type="checkbox"/> First Responder (for high school students) <input type="checkbox"/> EMT Basic / Initial Training <input type="checkbox"/> AEMT Basic / Initial Training <input type="checkbox"/> NREMT Transition Course <input type="checkbox"/> EMT Refresher Course <input type="checkbox"/> EMT-P Training Course <input type="checkbox"/> Continuing Education (CE) classes <input type="checkbox"/> Other (CPR etc.) _____
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I certify that all information is accurate, to the best of my knowledge, and that I have read and understand the program responsibilities and expectations as outlined in CA Code of Regulations, Title 22, Division 9, Chapter 3 (Advanced Emergency Medical Technician).

Signed, Course Director

Date

(ICEMA Use Only)

Date Application Received	Approval Date	Expiration Date	Receipt # / Date Paid

CHECKLIST FOR AEMT TRAINING PROGRAM APPROVAL

Materials to Submit for Program Approval		Page No.	Check Completed
1.	Table of Contents and checklist listing required information with corresponding page numbers (this form)		<input type="checkbox"/>
2.	Application form for AEMT program approval		<input type="checkbox"/>
3.	Statement of eligibility for program approval		<input type="checkbox"/>
4.	Written request to ICEMA for AEMT training program approval		<input type="checkbox"/>
5.	Statement verifying course content is equivalent to the US DOT National Emergency Medical Services Education Standards Emergency Medical Technician Instructional Guidelines (DOT HS 811 077A, January 2009)		<input type="checkbox"/>
6.	A course outline		<input type="checkbox"/>
7.	Performance objectives for each skill		<input type="checkbox"/>
8.	Provisions for supervised hospital clinical training, including standardized forms for evaluating Advanced EMT trainees.		<input type="checkbox"/>
9.	Provisions for supervised field internship, including standardized forms for evaluating Advanced EMT trainees.		<input type="checkbox"/>
10.	Evidence that the program provides adequate facilities, equipment, examination security, student record keeping, clinical training and field internship training.		<input type="checkbox"/>
11.	Samples of written and skills examinations used for periodic testing		<input type="checkbox"/>
12.	Final skills competency examination		<input type="checkbox"/>
13.	Final written examination		<input type="checkbox"/>
14.	Name and qualifications of the course director, program clinical coordinator, and principal instructor(s)		<input type="checkbox"/>
15.	Evidence the course director and principal instructor (s) have completed 40 hours in teaching methodology or equivalent per COR Title 22, Division 9, Chapter 3, §100109 (b) and (c6)		<input type="checkbox"/>
16.	Provisions for course completion by challenge, including a challenge examination (if different from final examination)		<input type="checkbox"/>
17.	Location where courses are to be offered and the proposed dates		<input type="checkbox"/>
18.	Application fees		<input type="checkbox"/>
19.	Copy of written agreement with 1 or more acute care hospital(s) to provide clinical experience as well as a clinical preceptor(s) to instruct and evaluate the student		<input type="checkbox"/>
20.	Copy of written agreement with an Advanced EMT or Paramedic service provider (s) to provide for field internship and provide a field preceptor(s) to directly supervise, instruct and evaluate students.		<input type="checkbox"/>

ICEMA STAFF USE ONLY

Comments: _____

AEMT TRAINING PROGRAM

HOSPITAL/AMBULANCE AFFILIATION INFORMATION

(ATTACH SIGNED AGREEMENT)

Name(s) of general acute care hospital(s) providing supervised in-hospital clinical experience for the AEMT student.

Name: _____
Address: _____
County: _____
Liaison: _____
Title: _____ Phone: _____
Email: _____

Name: _____
Address: _____
County: _____
Liaison: _____
Title: _____ Phone: _____
Email: _____

Name(s) of ambulance provider agencies providing supervised instruction on an operational ambulance for the AEMT student:

Level of Service

Name: _____ ☐ ALS ☐ BLS
Address: _____
County: _____
Liaison: _____
Title: _____ Phone: _____
Email: _____

Name: _____ ☐ ALS ☐ BLS
Address: _____
County: _____
Liaison: _____
Title: _____ Phone: _____
Email: _____

AEMT TRAINING PROGRAM

NOTIFICATION OF PROPOSED COURSE

PROVIDER NAME: _____

Address: _____

Location of Instruction: _____

County: _____

Address (if different): _____

INSTRUCTOR NAME: _____ **Phone:** _____

Email: _____

COURSES SCHEDULED:

☐ Basic Fee \$ _____

☐ Refresher Fee \$ _____

☐ Written & Skills Fee \$ _____

☐ Challenge Fee \$ _____

Course Starting Date

Course Completion Date

Date of Written Certifying Exam

Date of Skills Certifying Exam:

Submitted by: _____
Name (Course Director)

Signature

Date

NOTE: This notification should be submitted to ICEMA not less than thirty (30) days before the start of the course. The Course Director, Clinical Coordinator, Principal Instructor and Teaching Assistant Information must either be on file at ICEMA or attached to this form prior to the start of the course. All instructors must be approved by ICEMA prior to the start of any course.

**AEMT TRAINING PROGRAM
STUDENT PERFORMANCE DOCUMENTATION
CLINICAL TIME VERIFICATION
Clinical Internship/Hospital**

TO BE COMPLETED BY CLINICAL EVALUATOR:

Student Name: _____

Hospital Name: _____

Date: _____ Time In: _____ Time Out: _____

INITIAL APPROPRIATE BOX	Above Satisfactory	Satisfactory	Unsatisfactory
Appearance			
Dependability			
Initiative/Cooperation			
Knowledge of Required Skills			
Follows Directions			
Attitude and Courtesy Towards Patients and Staff			
Safety Precautions			
Appropriate Use of Tools and Equipment			

***Any rating marked "Unsatisfactory" must be explained in the comment section below.**

COMMENTS: _____

Signature of Evaluator

Signature of Student

**THIS FORM IS TO BE KEPT ON FILE AT THE TRAINING INSTITUTION AND
MUST BE SUBMITTED TO ICEMA UPON REQUEST**



INLAND COUNTIES EMERGENCY MEDICAL AGENCY
1425 SOUTH "D" STREET
SAN BERNARDINO, CA 92415-0060
909-388-5823 FAX: 909-388-5825

Training and Continuing Education Student Recap

Training Program Name _____ CE Provider No _____

Mailing Address _____ City _____ ST _____ ZIP _____

Training Site(s) Address _____ City _____ ST _____ ZIP _____

Course Director _____

Reporting Year (July 1 – June 30) _____ to _____

The following report must be submitted to ICEMA by all Training Courses and Continuing Education providers by July 15 each year whether or not any courses or CEs were provided.

Program Level (total number of students completing training reporting year)

Emergency Medical Response (EMR)

New _____

Renewal _____

Update _____

Emergency Medical Technician – Paramedic (EMT-P)

New _____

Renewal _____

Update _____

NREMT Transition _____

Emergency Medical Technician (EMT)

New _____

Renewal _____

Update _____

NREMT Transition _____

Mobile Intensive Care Nurse (MICN)

New _____

Renewal _____

Update _____

Advanced Emergency Medical Technician (AEMT)

New _____

Renewal _____

Update _____

Continuing Education

All CE Courses (not included above) _____